F:\P9\HEALTH\EC\RECON.008

Bill no.: Committee Print
Amendment no.:
Date offered: 10/27/05
Disposition: Agreed to, as amended, by 28 yeas and 22 nays

[COMMITTEE PRINT]

OCTOBER 21, 2005

TABLE OF SUBTITLES IN COMMITTEE PRINT

TITLE II—MEDICAID, KATRINA HEALTH CARE RELIEF, AND KATRINA AND RITA ENERGY RELIEF

Subtitle A—Medicaid

SEC. 3100. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Medicaid Reconciliation Act of 2005".

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS

SEC. 3101. FEDERAL UPPER PAYMENT LIMIT (FUL).

(a) IN GENERAL.—Subsection (e) of section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended to read as follows:

"(e) PHARMACY REIMBURSEMENT LIMITS.—

"(1) UPPER PAYMENT LIMIT FOR INGREDIENT COST OF COVERED OUTPATIENT DRUGS.—

"(A) IN GENERAL.—Subject to subparagraph (B), no Federal financial participation shall be available for payment for the ingredient

cost of a covered outpatient drug in excess of the upper payment limit for that drug established under paragraph (2).

"(B) OPTIONAL CARVE OUT.—A State may elect not to apply subparagraph (A) to payment for a covered outpatient drug dispensed by any (or any combination) of the following:

"(i) Pharmacies in a nursing facility.

"(ii) Pharmacies in hospitals.

"(iii) Specialty pharmacies (such as those dispensing only immunosuppressive drugs), as defined by the Secretary.

"(2) UPPER PAYMENT LIMIT.—

"(A) IN GENERAL.—Except as provided in subparagraph (D), the upper payment limit established under this paragraph for the ingredient cost of a—

"(i) single source drug, is 106 percent of the RAMP (as defined in subparagraph (B)(i)) for that drug; and

"(ii) multiple source drug is 120 percent of the volume weighted average RAMP for that drug (as defined under subparagraph (C)).

"(B) RAMP AND RELATED PROVISIONS.—For purposes of this subsection:

"(i) RAMP DEFINED.—The term 'RAMP' means, with respect to a covered outpatient drug by a manufacturer for a calendar quarter and subject to clause (ii) and (iii), the average price paid to a manufacturer for the drug in the United States in the quarter by wholesalers for drugs distributed to retail pharmacies, after deducting customary prompt pay discounts and excluding service fees that are paid by the manufacturer to an entity and that represent fair market value for a bona-fide service provided by the entity and that are not passed on, in whole in part, to a client or customer of the entity.

"(ii) SALES EXEMPTED FROM COMPUTATION.—The RAMP under clause (i) shall be calculated without regard to—

"(I) sales exempt from inclusion in the determination of best price under subsection (c)(1)(C)(i); and

"(II) such other sales as the Secretary identifies as sales to an entity

that are merely nominal in amount under subsection (c)(1)(C)(ii)(III).

"(iii) SALE PRICE NET OF DISCOUNTS.—In calculating the RAMP under clause (i), such AMP shall include any of the following:

"(I) Cash discounts and volume discounts.

"(II) Free goods that are contingent upon any purchase requirement or agreement.

"(III) Sales at a nominal price that are contingent upon any purchase requirement or agreement.

"(IV) Chargebacks, rebates provided to a pharmacy (not including rebates provided under an agreement under this section), or any other direct or indirect discounts.

"(V) Any other price concessions, which may be based on recommendations of the Inspector General of the Department of Health and Human Services, that would result in a reduction of the cost to the purchaser.

"(iv) RETAIL PHARMACY.—For purposes of this subsection, the term 'retail pharmacy' does not include mail-order only pharmacies or pharmacies at nursing facilities and homes.

"(C) VOLUME WEIGHTED AVERAGE RAMP DEFINED.—For purposes of subparagraph (A), the volume weighted average RAMP for a covered outpatient drug means, with respect to a calendar quarter, the RAMP paid to all manufacturers by wholesalers for the drug, weighted by volume for retail pharmacies for the entire class of drugs with the same chemical composition and dosage form. Such weighted average shall be a volume-weighted average for all National Drug Codes (NDC) assigned to the drug product and shall be computed using the same methodology as is used in computing the weighted average of average sale prices under section 1847A(b)(3).

"(D) EXCEPTION FOR INITIAL SALES PERIODS.—In the case of a single source drug during an initial sales period (not to exceed 2 calendar quarters) in which data on sales for the drug are not sufficiently available from the

manufacturer to compute the RAMP or the weighted average RAMP under subparagraph (C), the upper payment limit for the ingredient cost of such drug during such period shall be the wholesale acquisition cost (as defined in section 1847A(c)(6)(B)) for the drug.

"(E) UPDATES; DATA COLLECTION.—

"(i) FREQUENCY OF DETERMINATION.—The Secretary shall update the upper payment limits applicable under this paragraph on at least a quarterly basis, taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'.

"(ii) COLLECTION OF DATA.—Data on RAMP is collected under subsection (b)(3)(A)(iv).

"(F) AUTHORITY TO ENTER CONTRACTS.—The Secretary may enter into contracts with appropriate entities to determine sales prices and other data necessary to calculate the upper payment limit for a covered

outpatient drug established under this subsection and to calculate that payment limit.

"(3) DISPENSING FEES.—

"(A) IN GENERAL.—A State which provides medical assistance for covered outpatient drugs shall pay a dispensing fee for each covered outpatient drug for which Federal financial participation is available in accordance with this section in accordance with this paragraph.

"(B) DISPENSING FEE PAYMENT FOR MULTIPLE SOURCE DRUGS.—A State shall establish a dispensing fee under this title for a covered outpatient drugs that is a multiple source drug that is not less than $8 per prescription (as defined by the Secretary).

"(C) VARIATION IN DISPENSING FEES.—A State may vary the amount of such dispensing fees consistent with subparagraph (B) to take into account the special circumstances of—

"(i) pharmacies serving rural and underserved areas; and

"(ii) sole community pharmacies.

"(4) EFFECT ON STATE MAXIMUM ALLOWABLE COST LIMITATIONS.—This section shall not supersede or affect provisions in effect prior to January

1, 1991, or after December 31, 1994, relating to any maximum allowable cost limitation established by a State for payment by the State for covered outpatient drugs, and rebates shall be made under this section without regard to whether or not payment by the State for such drugs is subject to such a limitation or the amount of such a limitation.".

(b) CONFORMING AMENDMENTS.—

(1) Subsection (b)(3)(D) of such section is amended—

(A) by striking "and" at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting ", and"; and

(C) by inserting after clause (iv) the following new clause:

"(iv) to States to carry out this title.".

(2) Section 1903(i)(10) of such Act (42 U.S.C. 1396b(i)(10)) is amended—

(A) in subparagraph (A), by striking "and" at the end;

(B) in subparagraph (B), by striking "or" at the end and inserting "and"; and

(C) by adding at the end the following:

"(C) with respect to any amount expended for the ingredient cost of a covered outpatient drug that exceeds the upper payment limit for that drug established and applied under section 1927(e); or".

(c) EFFECTIVE DATE.—The amendments made by this section take effect with respect to a State on the later of—

(1) January 1, 2007; or

(2) the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(d) GAO STUDY ON DISPENSING FEES.—The Comptroller General of the United States shall conduct a study on the appropriateness in payment levels to pharmacies for dispensing fees under the medicaid program. Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study.

(e) IG REPORT ON USE OF RAMP.—Not later than 1 year after the date of the enactment of this Act, the Inspector General in the Department of Health and Human Services shall submit to Congress a report on—

(1) the appropriateness of using the RAMP, rather than the average manufacturer price or other price measures, as the basis for establishing a Fed-

eral upper payment limit for reimbursement for covered outpatient drugs under the medicaid program; and

(2) payment of specialty pharmacies under the Medicaid program for covered outpatient drugs.

SEC. 3102. COLLECTION AND SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.

(a) IN GENERAL.—Section 1927(a) of the Social Security Act (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following new paragraph:

"(7) REQUIREMENT FOR SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.—

"(A) SINGLE SOURCE DRUGS.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a single source drug or biological that is physician administered (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the

drug in order to secure rebates under this section.

"(B) MULTIPLE SOURCE DRUGS.—

"(i) DEVELOPMENT OF REPORTING METHODOLOGY.—Not later than January 1, 2007, the Secretary shall develop and publish a methodology for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of each physician administered multiple source drug in order to secure rebates under this section.

"(ii) IDENTIFICATION OF MOST FREQUENTLY PHYSICIAN ADMINISTERED MULTIPLE SOURCE DRUGS.—Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest volume of physician administered dispensing under this title. The Secretary may modify such list from year to year to reflect changes in such volume.

"(iii) REQUIREMENT.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (ii), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section.

"(C) HARDSHIP WAIVER.—The Secretary may delay the application of subparagraph (A) or (B), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.".

(b) LIMITATION ON PAYMENT.—Section 1903(i)(10) of such Act (42 U.S.C. 1396b(i)(10)), as amended by section 3101(b)(2), is amended—

(1) by striking "and" at the end of subparagraph (B);

(2) by striking "; or" at the end of subparagraph (C) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(D) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section; or".

SEC. 3103. IMPROVED REGULATION OF AUTHORIZED GENERIC DRUGS AND OTHER DRUGS SOLD UNDER A NEW DRUG APPLICATION APPROVED UNDER SECTION 505(C) OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) INCLUSION WITH OTHER REPORTED AVERAGE MANUFACTURER AND BEST PRICES.—Section 1927(b)(3)(A) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

(1) by striking clause (i) and inserting the following:

"(i) not later than 30 days after the last day of each rebate period under the agreement—

"(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for such drugs that are authorized generic drugs or are any other drugs sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and

"(II) for single source drugs, innovator multiple source drugs, authorized generic drugs, and any other drugs sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;"; and

(2) in clause (ii), by inserting "(including for such drugs that are authorized generic drugs or are any other drugs sold under a new drug application

approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)" after "drugs".

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (c)(1)(C)—

(A) in clause (i), in the matter preceding subclause (I), by striking "or innovator multiple source drug of a manufacturer" and inserting ", innovator multiple source drug, or authorized generic drug of a manufacturer, or any other drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act"; and

(B) in clause (ii)—

(i) in subclause (II), by striking "and" at the end;

(ii) in subclause (III), by striking the period at the end and inserting "; and"; and

(iii) by adding at the end the following:

"(IV) in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic

drug or any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, shall be inclusive of the lowest price for such authorized generic or other drug available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).''; and

(2) in subsection (k)—

(A) in paragraph (1)—

(i) by striking ''The term'' and inserting the following:

''(A) IN GENERAL.—The term''; and

(ii) by adding at the end the following:

''(B) INCLUSION OF AUTHORIZED GENERIC DRUGS.—In the case of a manufacturer that approves, allows, or otherwise permits an au-

thorized generic drug or any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, such term shall be inclusive of the average price paid for such authorized generic or other drug by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts."; and

(B) by adding at the end the following:

"(10) AUTHORIZED GENERIC DRUG.—The term 'authorized generic drug' means a listed drug (as that term is used in section 505(j) of the Federal Food, Drug, and Cosmetic Act that—

"(A) has been approved under section 505(c) of such Act; and

"(B) is marketed, sold, or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

SEC. 3104. PRESCRIPTION DRUG INNOVATION PAYMENTS.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

"(x) PRESCRIPTION DRUG INNOVATION PAYMENTS.—

"(1) IN GENERAL.—In addition to the payments provided under subsection (a) and subject to paragraph (4), the Secretary shall provide for payments under subsection (a) to qualifying States to reward States for the introduction of innovative methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization. Such methods may include the following:

"(A) INCREASING GENERIC UTILIZATION.—Increasing the utilization of generic drugs through the use of education programs to educate patients and physicians on the benefits of such drugs.

"(B) MEDICATION RISK MANAGEMENT PROGRAMS.—The use of medication risk management programs.

"(2) APPLICATION; TERMS AND CONDITIONS.—No payments shall be made to a State under this subsection unless the State applied to the Secretary for such payments in a form, manner, and time specified by the Secretary. Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

"(3) FUNDING.—

"(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

"(i) $50,000,000 for 2006; and

"(ii) $50,000,000 for 2007.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States.

"(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

"(D) NO DOUBLE DIPPING.—Funds provided under this subsection shall be conditioned upon the Secretary receives satisfactory assurances that the aggregate Federal expenditures under such title are not greater than the amount that would be paid if such payment had been made.

"(E) EXPENDITURES.—For purposes of this subsection, expenditures for outpatient prescription drugs shall include expenditures for ingredient costs as well as dispensing fees.".

CHAPTER 2—REFORM OF ASSET TRANSFER RULES

SEC. 3111. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.

(a) LENGTHENING LOOK-BACK PERIOD FOR ALL DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is

amended by inserting "or in the case of any other disposal of assets made on or after the date of the enactment of the Medicaid Reconciliation Act of 2005" before ", 60 months".

(b) CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended—

(1) by striking "(D) The date" and inserting "(D)(i) In the case of a transfer of asset made before the date of the enactment of the Medicaid Reconciliation Act of 2005, the date"; and

(2) by adding at the end the following new clause:

"(ii) In the case of a transfer of asset made on or after the date of the enactment of the Medicaid Reconciliation Act of 2005, the date specified in this subparagraph is the first day of a month during or before which assets have been transferred for less than fair market value and during which the individual—

"(I) is an institutionalized individual (or, at State option, is a noninstitutionalized individual);

"(II) is eligible for medical assistance under the State plan (or would be so eligible but for the application of this subsection); and

"(III) is not in any other period of ineligibility under this subsection.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers made after the date of the enactment of this Act.

(d) AVAILABILITY OF HARDSHIP WAIVERS.—

(1) IN GENERAL.—Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

(A) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

(i) of medical care such that the individual's health or life would be endangered; or

(ii) of food, clothing, shelter, or other necessities of life; and

(B) which provides for—

(i) notice to recipients that an undue hardship exception exists;

(ii) a timely process for determining whether an undue hardship waiver will be granted; and

(iii) a process under which an adverse determination can be appealed.

(2) CONSTRUCTION.—Nothing in this section (or the amendments made by this section) shall be construed as affecting the application of section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D)) or regulations promulgated or instructions issued to carry out such section.

(e) TRANSITIONAL COMPENSATION POOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish by regulation a program to provide funds to States (as defined for purposes of title XIX of the Social Security Act) for the compensation of institutional health care providers that incur additional bad debt as a direct result of the implementation of the amendments made by this section.

(2) PROCEDURE.—Funds shall only be made available under this subsection upon such terms and conditions, including the approval of an application, as the Secretary shall specify

(3) ALLOCATION OF FUNDS.—The Secretary shall establish a method for allocating funds available under paragraph (4) among the qualifying States. Such method shall take into account the

amount of the additional bad debt described in paragraph (1) for institutional health care providers in the respective States.

(4) FUNDING.—

(A) IN GENERAL.—There are hereby authorized and appropriated to carry out this subsection, $30,000,000 for fiscal year 2006 and $30,000,000 for fiscal year 2007.

(B) AVAILABILITY.—Funds appropriated under subparagraph (A) for a fiscal year shall remain available for obligation through the end of the following fiscal year.

(f) ADDITIONAL PROVISIONS ON HARDSHIP WAIVERS.—

(1) APPLICATION BY FACILITY.—Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended—

(A) by striking the semicolon at the end of subparagraph (D) and inserting a period; and

(B) by adding after and below such subparagraph the following:

"The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver applica-

tion on behalf of the individual with the consent of the individual or the legal guardian of the individual.".

(2) AUTHORITY TO MAKE BED HOLD PAYMENTS FOR HARDSHIP APPLICANTS.—Such section is further amended by adding at the end the following: "While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application provides a prima facie case of qualification for such a waiver, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility.".

SEC. 3112. DISCLOSURE AND TREATMENT OF ANNUITIES AND OF LARGE TRANSACTIONS.

(a) IN GENERAL.—Section 1917 of the Social Security Act is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

"(e)(1) In order to meet the requirements of this subsection for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including

any recertification of eligibility for such assistance) shall disclose the following:

"(A) A description of any interest the individual has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset.

"(B) Full information (as specified by the Secretary) concerning any transaction involving the transfer or disposal of assets during the previous period of 60 months, if the transaction exceeded $100,000, without regard to whether the transfer or disposal was for fair market value. For purposes of applying the previous sentence under this subsection, all transactions of $5,000 or more occurring within a 12-month period shall be treated as a single transaction. The dollar amounts specified in the first and second sentences of this subparagraph shall be increased, beginning with 2007, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000 in the case of the first sentence and $100 in the case of the second sentence.

Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such a annuity by virtue of the provision of such medical assistance.

"(2)(A) In the case of any annuity in which an institutionalized individual has an interest, if medical assistance is furnished to the individual for services described in subsection (c)(1)(C)(i), by virtue of the provision of such assistance the State becomes the remainder beneficiary in the first position for the total amount of such medical assistance paid on behalf of the individual under this title.

"(B) In the case of disclosure concerning an annuity under paragraph (1)(A), the State shall notify issuer of the annuity of the right of the State under subparagraph (A) as a preferred remainderman interests in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under subparagraph (A).

"(C) In the case of such an issuer receiving notice under subparagraph (B), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount

that was being withdrawn at the time of the most recent disclosure described in paragraph (1)(A). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

"(3)(A) For purposes of subsection (c)(1), a transaction described in paragraph (1)(B) shall be deemed as the transfer of an asset for less than fair market value unless the individual demonstrates to the satisfaction of the State that the transfer of the asset was for fair market value.

"(B) The Secretary may provide guidance to States on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as a transfer of asset for fair market value.

"(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1)(A).".

(b) CONFORMING AMENDMENT.—Section 1902(a)(18) of such Act (42 U.S.C. 1396a(a)(18)) is amended by inserting before the semicolon at the end the following: ", including the requirements of subsection (e)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions (including the pur-

chase of an annuity) occurring on or after the date of the enactment of this Act.

SEC. 3113. APPLICATION OF "INCOME-FIRST" RULE IN APPLYING COMMUNITY SPOUSE'S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Section 1924(d) of the Social Security Act (42 U.S.C. 1396r–5(d)) is amended by adding at the end the following new paragraph:

"(6) APPLICATION OF 'INCOME FIRST' RULE FOR FUNDING COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE.—For purposes of this subsection and subsection (e), any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse monthly income allowance under paragraph (1)(B) shall be first made from income of the institutionalized spouse and then only when the income is not available from the resources of such institutionalized spouse.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 3114. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) IN GENERAL.—Section 1917 of the Social Security Act, as amended by section 3112, is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

"(f)(1) Notwithstanding any other provision of this title, subject to paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if individual's equity interest in the individual's home exceeds $500,000.

"(2) Paragraph (1) shall not apply with respect to an individual if—

"(A) the spouse of such individual, or

"(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual's home.

"(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 3115. TREATMENT OF SPOUSAL ASSIGNMENTS OF RIGHTS FOR INSTITUTIONALIZED SPOUSES RECEIVING MEDICAID LONG-TERM CARE BENEFITS.

(a) IN GENERAL.—Section 1924(c)(3)(A) of the Social Security Act (42 U.S.C. 1396r–5(c)(3)(A)) is amended by inserting before the semicolon the following: "and such community spouse makes such resources available for the cost of such care".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to eligibility for take effect on January 1, 2006, and shall apply to assignments of rights of support executed before, on, or after such date.

(2) TRANSITION.—In effecting such amendment in the case of an individual who as of January 1, 2006, has been determined eligible for benefits under title XIX of the Social Security Act, a State (as defined for purposes of such title) may apply section 1924(c)(2) of the Social Security Act by substituting "January 1, 2006, or a later date specified by the State" for "at the time of application for benefits of this title" in order to redetermine initial eligibility for such benefits taking such amendment into account.

CHAPTER 3—FLEXIBILITY IN COST-SHARING AND BENEFITS

SEC. 3121. STATE OPTION FOR ALTERNATIVE MEDICAID PREMIUMS AND COST-SHARING.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1916 the following new section:

"STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST-SHARING

"SEC. 1916A. (a) STATE FLEXIBILITY.—

"(1) IN GENERAL.—Notwithstanding section 1916, a State, at its option, may impose premiums and cost-sharing for any class or group of individuals and for any type of services (and may vary such premiums and cost-sharing among such class, group,

or type, including through the use of tiered cost-sharing for prescription drugs) consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) section 1916(g).

"(2) DEFINITIONS.—In this section:

"(A) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

"(B) COST-SHARING.—The term 'cost-sharing' includes any deduction, deductible, co-payment, or similar charge.

"(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—Subject to the succeeding provisions of this section—

"(1) INDIVIDUALS WITH FAMILY INCOME BELOW 100 PERCENT OF POVERTY LEVEL.—In the case of an individual whose family income does not exceed 100 percent of the Federal poverty level applicable to a family of the size involved, subject to the succeeding provisions of this section, the limitations otherwise provided under subsections (a) and (b) of section 1916 shall continue to apply and no enrollment fee, premium, or similar charge will be imposed under the plan, except that subject to the succeeding provisions of this section, the total annual aggregate amount of cost-sharing imposed for

all individuals in the family may not exceed 5 percent of the family income of the family involved for the year involved.

"(2) INDIVIDUALS WITH FAMILY INCOME ABOVE 100 PERCENT OF POVERTY LEVEL.—In the case of an individual whose family income exceeds 100 percent of the Federal poverty level applicable to a family of the size involved, subject to the succeeding provisions of this section, the total annual aggregate amount of premiums and cost-sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved for the year involved.

"(3) ADDITIONAL LIMITATIONS.—Subject to the succeeding provisions of this section, no cost-sharing shall be imposed under this section with respect to the following:

"(A) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom adoption or foster care assistance is made available under part E of title IV without regard to age.

"(B) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

"(C) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

"(D) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

"(E) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(F) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

"(G) Family planning services and supplies described in section 1905(a)(4)(C).

Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals or services from cost-sharing under this section.

"(5) INDEXING NOMINAL AMOUNTS.—In applying section 1916 under paragraph (1) with respect to cost-sharing that is 'nominal' in amount—

"(A) the Secretary shall phase-in an increase in such amount over a 3 year period (beginning January 1, 2006) so that—

"(i) a $3 nominal amount in 2005 would be increased to be a $5 nominal amount in 2008; and

"(ii) other nominal amounts would be increased by a proportional amount (with appropriate rounding) during such period; and

"(B) the Secretary shall increase such 'nominal' amounts for each subsequent year (beginning with 2009) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.

"(6) DETERMINATIONS OF FAMILY INCOME.—In applying this subsection, family income shall be determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

"(7) POVERTY LINE DEFINED.—For purposes of this subsection, the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"(8) CONSTRUCTION.—Nothing in this section shall be construed—

"(A) as preventing a State from further limiting the premiums and cost-sharing imposed under this section beyond the limitations provided under this subsection;

"(B) as affecting the authority of the Secretary to waive limitations on premiums and cost-sharing under this subsection; or

"(C) as affecting any such waiver of requirements in effect under this title before the

date of the enactment of this section with regard to the imposition of premiums and cost-sharing.

"(d) ENFORCEABILITY OF PREMIUMS AND OTHER COST-SHARING.—

"(1) PREMIUMS.—Notwithstanding section 1916(c)(3), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium. A State may apply the previous sentence for some or all classes or types of beneficiaries.

"(2) COST-SHARING.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care, items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost-sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider

from reducing or waiving the application of such cost-sharing.".

(b) GAO STUDY OF IMPACT OF PREMIUMS AND COST-SHARING.—The Comptroller General of the United States shall conduct a study of the impact of premiums and cost-sharing under the medicaid program on access to, and utilization of, services. Not later than January 1, 2008, the Comptroller General shall submit a report to the Congress on such study.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost-sharing imposed for items and services furnished on or after January 1, 2006.

SEC. 3122. SPECIAL RULES FOR COST-SHARING FOR PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 3121, is amended by inserting after subsection (b) the following new subsection:

"(c) SPECIAL RULES FOR COST-SHARING FOR PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—In order to encourage beneficiaries to use drugs (in this subsection referred to as 'preferred drugs') identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State),

with respect to one or more classes of beneficiaries State may—

"(A) provide an increase in cost-sharing (above the level otherwise permitted under section 1916 or subsection (b), but consistent with paragraphs (2) and (3)) for any beneficiary with respect to drugs that are not preferred drugs within a class; and

"(B) waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class.

"(2) LIMITATION.—In no case may the increase in cost-sharing under paragraph (1)(A) with respect to a non-preferred drug exceed the lesser of the following:

"(A) COST DIFFERENTIAL.—The amount (as estimated from time to time by the State) by which the amount of payment to the pharmacy provided by the State under this title for the non-preferred drug exceeds such amount for the next lowest cost preferred drug in the same class.

"(B) MULTIPLE OF NOMINAL COST-SHARING.—In the case of an individual whose family income is—

"(i) below 100 percent of the poverty line applicable to a family of the size involved, two times the amount of nominal cost sharing (as otherwise determined under subsection (b));

"(ii) at least 100 percent, but below 150 percent, of the poverty line applicable to a family of the size involved, three times the amount of nominal cost sharing (as otherwise determined under subsection (b)); or

"(iii) at least 150 percent of the poverty line applicable to a family of the size involved, four times the amount of nominal cost sharing (as otherwise determined under subsection (b)).

"(3) WAIVER.—In carrying out paragraph (1), a State shall provide for the application of cost-sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if a physician certifies that the use of the preferred drug for treatment of the condition is likely to create adverse health effects.

"(4) EXCLUSION AUTHORITY.—Nothing in this subsection shall be construed as preventing a State

from excluding from paragraph (1) specified drugs or classes of drugs.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost-sharing imposed for items and services furnished on or after October 1, 2006.

SEC. 3123. EMERGENCY ROOM COPAYMENTS FOR NON-EMERGENCY CARE.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 3121 and as amended by section 3122, is further amended by adding at the end the following new subsection:

"(f) STATE OPTION FOR INCREASE IN COST-SHARING FOR NON-EMERGENCY CARE FURNISHED IN AN HOSPITAL EMERGENCY ROOM.—

"(1) IN GENERAL.—Notwithstanding section 1916 or the previous provisions of this section, a State may, by amendment to its State plan under this title, provide for an increase in cost-sharing for non-emergency services furnished to an individual (within one or more classes of individuals specified by the State) in a hospital emergency department under this subsection if the following conditions are met:

"(A) ACCESS TO NON-EMERGENCY ROOM PROVIDER.—The individual has reasonably

available access (as defined by the Secretary) to an alternate non-emergency services provider with respect to such services.

"(B) NOTICE.—The physician or hospital must inform the beneficiary after the initial screening assessment, but before providing the non-emergency services, of the following:

"(i) The hospital may require the payment of the State specified cost-sharing before the service can be provided.

"(ii) The name and location of an alternate non-emergency services provider care provider (described in subparagraph (A)).

"(iii) The fact that such alternate provider can provide the services without the imposition of the increase in cost-sharing described in clause (i).

"(iv) The hospital can provide a referral to coordinate scheduling of this treatment.

Nothing in this section shall be construed as preventing a State from waiving cost-sharing otherwise applicable to services described in clause (iii).

"(2) LIMITATION FOR POOREST BENEFICIARIES.—In the case of an individual described in subsection (b)(1), the cost-sharing imposed under this subsection may not exceed twice the amount determined to be nominal under this section, subject to the percent of income limitation otherwise applicable under subsection (b)(1).

"(3) APPLICATION TO EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost-sharing due to the application of subparagraph (B), (C), (D), (H), or (I) of subsection (b)(4), there may be cost-sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as determined under this section) so long as no cost-sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the area of the hospital emergency department involved.

"(4) CONSTRUCTION.—Nothing in this section shall be construed—

"(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition; or

"(B) to modify any obligations under either State or Federal standards relating to the

application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization; or

"(C) to prevent a hospital from requiring, as a condition of providing non-emergency services, the payment of any applicable cost-sharing.

"(5) DETERMINATION STANDARD.—No hospital or physician that makes a determination with respect to the imposition of cost-sharing under this subsection shall be liable in any civil action or proceeding for such determination absent a finding by clear and convincing evidence of gross negligence by the hospital or physician.

"(6) DEFINITIONS.—For purposes of this subsection:

"(A) NON-EMERGENCY SERVICES.—The term 'non-emergency services' means any care or services furnished in a emergency department of a hospital that the hospital or physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment screening re-

quired to be provided by the hospital under section 1867.

"(B) ALTERNATE NON-EMERGENCY SERVICES PROVIDER.—The term 'alternative non-emergency services provider' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that provides clinically appropriate services for such diagnosis or treatment of the condition within clinically appropriate time of the provision of such non-emergency services.".

(b) GRANT FUNDS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 3104, is further amended by adding at the end the following new subsection:

"(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

"(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the estab-

lishment of alternate non-emergency service providers (as defined in section 1916A(f)(6)(B)), or networks of such providers, particularly in rural and otherwise underserved areas where beneficiaries under this title may not have regular access to providers of primary care services.

"(2) LIMITATION.—The total amount of payments under this subsection shall be equal to, and shall not exceed, $100,000,000 during the four-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers in partnership with local community hospitals.

"(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be

made in the same manner as other payments under section 1903(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to non-emergency services furnished on or after the date of the enactment of this Act.

SEC. 3124. USE OF BENCHMARK BENEFIT PACKAGES.

Title XIX of the Social Security Act is amended by redesignating section 1936 as section 1937 and by inserting after section 1935 the following new section:

"STATE FLEXIBILITY IN BENEFIT PACKAGES

"SEC. 1936. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

"(1) AUTHORITY.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, a State, at its option, provide for medical assistance under this title to individuals within one or more groups of individuals under the State plan through enrollment in coverage that provides—

"(i) benchmark coverage described in subsection (b)(1); or

"(ii) benchmark equivalent coverage described in subsection (b)(2).

"(B) LIMITATION.—The State may only exercise the option under subparagraph (A) for eligibility categories that had been established

before the date of the enactment of this section and may not apply such for individuals who, on such date, were enrolled in a group health plan.

"(C) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

"(D) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

"(2) APPLICATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within one or more categories of such individuals.

"(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enroll-

ment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

"(i) MANDATORY PREGNANT WOMEN AND CHILDREN.—The individual is a pregnant woman or child under 18 years of age who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

"(ii) SSI BENEFICIARIES.—The individual is an individual with respect to whom supplemental security income benefits are being paid under title XVI.

"(iii) DUAL ELIGIBLES.—The individual is entitled to benefits under any part of title XVIII.

"(iv) TERMINALLY ILL HOSPICE PATIENTS.—The individual is terminally ill and is receiving benefits for hospice care under this title.

"(v) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such

individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(vi) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.—The individual is medically frail or otherwise an individual with special medical needs (as identified in accordance with regulations of the Secretary).

"(vii) BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.—The individual qualifies based on medical condition for medical assistance for long-term care services under this title.

"(C) FULL-BENEFIT ELIGIBLE INDIVIDUALS.—

"(i) IN GENERAL.—For purposes of this paragraph, subject to clause (ii), the term 'full-benefit eligible individual' means for a State for a month an individual who is determined eligible by the State for medical assistance for full benefits under this

title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for full benefits under this title, as determined by the Secretary.

"(ii) EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.—Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

"(b) BENCHMARK BENEFIT PACKAGES.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), each of the following coverage shall be considered to be benchmark coverage:

"(A) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

"(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

"(C) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

"(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

"(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

"(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

"(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the following categories of basic services:

"(i) Inpatient and outpatient hospital services.

"(ii) Physicians' surgical and medical services.

"(iii) Laboratory and x-ray services.

"(iv) Well-baby and well-child care, including age-appropriate immunizations.

"(v) Other appropriate preventive services, as designated by the Secretary.

"(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

"(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

"(i) Coverage of prescription drugs.

"(ii) Mental health services.

"(iii) Vision services.

"(iv) Hearing services.

"(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

"(A) by an individual who is a member of the American Academy of Actuaries;

"(B) using generally accepted actuarial principles and methodologies;

"(C) using a standardized set of utilization and price factors;

"(D) using a standardized population that is representative of the population involved;

"(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

"(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

"(G) taking into account the ability of a State to reduce benefits by taking into account

the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).".

CHAPTER 4—EXPANDED ACCESS TO CERTAIN BENEFITS

SEC. 3131. STATE OPTION OF PROVIDING CASH & COUNSELING PROGRAMS.

Title XIX of the Social Security Act, as amended by section 3124, is amended by redesignating section 1937 as section 1938 and by inserting after section 1936 the following new section:

"OPTIONAL USE OF CASH AND COUNSELING PROGRAM IN CONNECTION WITH PERSONAL CARE SERVICES

"SEC. 1937. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—A State may amend its State plan under this title to establish and operate, in connection with its provision of cash and counseling covered services under this title, a cash and counseling program in accordance with this section.

"(2) CASH AND COUNSELING COVERED SERVICES DEFINED.—For purposes of this section, the

term 'cash and counseling covered services' means personal care and related services and includes home or community-based services of the type described in section 1915(c), services described in section 2110(a)(14), and related support services, such as personal care and respite care.

"(b) CASH AND COUNSELING PROGRAM DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'cash and counseling program' means a program operated by a State in accordance with this section under which eligible participants, within an approved self-directed services plan and budget, purchase cash and counseling covered services and permits such participants to hire, supervise, and manage the individuals providing such services.

"(2) PROGRAM PROVISIONS.—

"(A) USE OF FISCAL INTERMEDIARY.—Each cash and counseling program shall require participants to use a fiscal intermediary to administer payments to providers under the program.

"(B) USE OF SAVINGS.—Each such program shall permit a participant to use—

"(i) notwithstanding any other provision of law, amounts provided under the

program for cash payments to legally responsible relatives (such as a spouse or a parent); and

"(ii) moneys otherwise saved under an approved self-directed services plan and budget to purchase items that increase independence (such as a microwave or an accessibility ramp).

"(C) MONITORING ENROLLMENT AND COSTS.—Each such program shall monitor and report quarterly to the Secretary on enrollment and costs under the program.

"(c) ELIGIBLE PARTICIPANTS.—For purposes of this section, the term 'eligible participant' means, with respect to a cash and counseling program, an individual who—

"(1) is eligible for medical assistance under this title with respect to cash and counseling covered services (whether under a waiver under section 1915(c) or otherwise) and has an approved self-directed services plan and budget (as defined in subsection (d)) in connection with such participation and does not receive other medical assistance for such services under this title (than under such plan and budget) while participating in the cash and counseling program;

"(2) qualifies as a disabled individual under section 1614(a);

"(3) language based on MFI demo language: "(C) at the time the individual begins participation in a cash and counseling program, resides in—

"(A) a single-family home owned or leased by the individual or the individual's family member; or

"(B) an apartment with an individual lease, lockable access and egress, and living, sleeping, and cooking areas over which the occupant has domain and control; and

"(4) voluntarily elects to participate in the cash and counseling program.

"(d) APPROVED SELF-DIRECTED SERVICES PLAN AND BUDGET.—For purposes of this section, the term 'approved self-directed services plan and budget' means, with respect to a participant, the establishment of a plan and budget for the provision of cash and counseling covered services through self-direction consistent with this following requirements:

"(1) SELF-DIRECTION.—The participant (or, in the case of a participant who is a minor child, the participant's parent or guardian) exercises choice and control over the budget, planning, and purchase

of cash and counseling covered services, including the amount, duration, and scope, provider, and location of service provision.

"(2) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participant for such services.

"(3) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

"(A) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

"(B) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

"(4) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection,

and includes a calculation of the expected cost of such services if those services were not self-directed.

"(5) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.".

SEC. 3132. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

(a) TMA EXTENSION.—

(1) IN GENERAL.—Section 1925(f) of the Social Security Act (42 U.S.C. 1396r–6(f)) is amended by striking "September 30, 2003" and inserting "December 31, 2006".

(2) CONFORMING AMENDMENT.—Section 1902(e)(1)(B) of such Act (42 U.S.C. 1396a(e)(1)(B)) is amended by striking "September 30, 2003" and inserting "the last date (if any) on which section 1925 applies under subsection (f) of that section or otherwise".

(b) ABSTINENCE EDUCATION.—Section 510(d) of the Social Security Act (42 U.S.C. 710(d)) is amended by striking "2003" and inserting "2006 and an additional $12,500,000 for the first calendar quarter in fiscal year 2007".

SEC. 3133. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(1) in paragraph (1)(C)(ii), by inserting "or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))" after "1993,"; and

(2) by adding at the end of paragraph (1)(C) the following new clauses:

"(iii) For purposes of this paragraph, the term 'qualified State long-term care insurance partnership' means a State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), if the following requirements are met:

"(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

"(II) The policy is a qualified long-term care insurance policy (as defined in section 7702(b) of the Internal Revenue Code of 1986) issued on or after the date of approval of the plan amendment.

"(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection.

"(IV) The State plan amendment provides for some level of agent training for the sale of long-term care insurance policies under the partnership.

"(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with regulations of the Secretary (promulgated after consultation with the States), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the

Secretary determines may be appropriate to the administration of such partnerships.

"(VI) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged.

"(iv) The Secretary—

"(I) as appropriate, shall provide copies of the reports described in clause (iii)(VII) to the State involved; and

"(II) shall promote the education of consumers regarding qualified State long-term care insurance partnerships.".

(b) CONSTRUCTION.—Nothing in the amendments made by subsection (a) shall be construed as affecting the treatment of long-term care insurance policies that are or were provided under a State plan amendment described

in section 1916(b)(1)(C)(ii) of the Social Security Act that was approved as of May 15, 1993.

(c) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by subsection (a) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the date of the enactment of this Act.

(d) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary may develop, in consultation with the States and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships.

SEC. 3134. HEALTH OPPORTUNITY ACCOUNTS.

Title XIX of the Social Security Act, as amended by sections 3124 and 3131, is amended—

(1) by redesignating section 1938 as section 1939; and

(2) by inserting after section 1937 the following new section:

"HEALTH OPPORTUNITY ACCOUNTS

"SEC. 1938. (a) AUTHORITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish a demonstration program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a 'State demonstration program'.

"(2) INITIAL DEMONSTRATION.—The demonstration program under this section shall begin on January 1, 2006. During the first 5 years of such program, the Secretary shall not approve more than 10 State demonstration programs, with each State demonstration program covering one or more geographic areas specified by the State. After such 5-year period—

"(A) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies,

that a State demonstration program previously implemented has been unsuccessful, such a demonstration program may be extended or made permanent in the State; and

"(B) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration program previously implemented were unsuccessful, other States may implement State demonstration programs.

"(3) APPROVAL.—The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

"(A) Creating patient awareness of the high cost of medical care.

"(B) Providing incentives to patients to seek preventive care services.

"(C) Reducing inappropriate use of health care services.

"(D) Enabling patients to take responsibility for health outcomes.

"(E) Providing enrollment counselors and ongoing education activities.

"(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

"(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

"(4) NO REQUIREMENT FOR STATEWIDENESS.—Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implement of a State demonstration program on a Statewide basis.

"(5) REPORTS.—The Secretary shall periodically submit to Congress reports regarding the success of State demonstration programs.

"(b) ELIGIBLE POPULATION GROUPS.—

"(1) IN GENERAL.—A State demonstration program under this section shall specify the eligible population groups consistent with paragraph (2).

"(2) ELIGIBILITY LIMITATIONS DURING INITIAL DEMONSTRATION PERIOD.—During the initial 5 years of the demonstration program under this section, a State demonstration project shall not apply to any of the following individuals:

"(A) Individuals who are 65 years of age or older.

"(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on such disability.

"(C) Individuals who are eligible for medical assistance under this title only because they are (or were within previous 60 days) pregnant.

"(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

"(3) LIMITATIONS.—

"(A) STATE OPTION.—This subsection shall not be construed as preventing a State from further limiting eligibility to individuals who are likely to be eligible for medical assistance for a period of one year or longer.

"(B) ON ENROLLEES IN MEDICAID MANAGED CARE ORGANIZATIONS.—Insofar as the

State provides for eligibility of individuals who are enrolled in medicaid managed care organizations, such individuals may participate in the State demonstration project only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

"(i) In no case may the number of such individuals enrolled in the organization who participate in the project exceed 5 percent of the total number of individuals enrolled in such organization.

"(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

"(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

"(4) VOLUNTARY PARTICIPATION.—An eligible individual shall be enrolled in a State demonstration project only if the individual voluntarily enrolls. Such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

"(c) ALTERNATIVE BENEFITS.—

"(1) IN GENERAL.—The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

"(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this title after an annual deductible described in paragraph (2) has been met; and

"(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

"(2) ANNUAL DEDUCTIBLE.—The amount of the annual deductible described in paragraph (1)(A)

shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection (d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(ii).

"(3) ACCESS TO NEGOTIATED PROVIDER PAYMENT RATES.—

"(A) FEE-FOR-SERVICE ENROLLEES.—In the case of an individual who is participating in a State demonstration project and who is not enrolled with a medicaid managed care organization, the State shall provide that the individual may obtain demonstration project medicaid services from—

"(i) any participating provider under this title at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

"(ii) any provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this title if the deductible de-

scribed in paragraph (1)(A) was not applicable.

"(B) TREATMENT UNDER MEDICAID MANAGED CARE PLANS.—In the case of an individual who is participating in a State demonstration project and is enrolled with a medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration project medicaid services from any provider under such organization at payment rates that do not the payment rate that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable.

"(C) COMPUTATION.—The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost-sharing that would be otherwise applicable under section 1916.

"(D) DEFINITIONS.—For purposes of this paragraph:

"(i) The term 'demonstration project medicaid services' means, with respect to an individual participating in a State dem-

onstration project, services for which the individual would be provided medical assistance under this title but for the application of the deductible described in paragraph (1)(A).

"(ii) The term 'participating provider' means—

"(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

"(II) with respect to an individual described in subparagraph (B) who is enrolled in a medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this title.

"(4) NO EFFECT ON SUBSEQUENT BENEFITS.—Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall

consist of the benefits otherwise provided to the individual, including cost-sharing relating to such benefits.

"(5) OVERRIDING COST-SHARING AND COMPARABILITY REQUIREMENTS FOR ALTERNATIVE BENEFITS.—The provisions of this title relating to cost-sharing for benefits (including section 1916) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1902(a)(10)(B) (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

"(6) TREATMENT AS MEDICAL ASSISTANCE.—Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1903(a).

"(7) USE OF TIERED DEDUCTIBLE AND COST-SHARING.—

"(A) IN GENERAL.—A State—

"(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family

involved so long as it does not favor families with higher income over those with lower income; and

"(ii) may vary the amount of the maximum out-of-pocket cost-sharing (as defined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

"(B) MAXIMUM OUT-OF-POCKET COST-SHARING.—For purposes of subparagraph (A)(ii), the term 'maximum out-of-pocket cost-sharing' means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

"(8) CONTRIBUTIONS BY EMPLOYERS.—Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

"(d) HEALTH OPPORTUNITY ACCOUNT.—

"(1) IN GENERAL.—For purposes of this section, the term 'health opportunity account' means an account that meets the requirements of this subsection.

"(2) CONTRIBUTIONS.—

"(A) IN GENERAL.—No contribution may be made into a health opportunity account except—

"(i) contributions by the State under this title; and

"(ii) contributions by other persons and entities, such as charitable organizations.

"(B) STATE CONTRIBUTION.—A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

"(C) LIMITATION ON ANNUAL STATE CONTRIBUTION PROVIDED AND PERMITTING IMPOSITION OF MAXIMUM ACCOUNT BALANCE.—

"(i) IN GENERAL.—A State—

"(I) may impose limitations on the maximum contributions that may be deposited under subparagraph

(A)(i) into a health opportunity account in a year;

"(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

"(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

"(ii) INDEXING OF DOLLAR LIMITATIONS.—For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by an percentage that reflects the annual percentage increase in the medical

care component of the consumer price index for all urban consumers.

"(iii) BUDGET NEUTRAL ADJUSTMENT.—A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause (ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

"(D) LIMITATIONS ON FEDERAL MATCHING.—

"(i) STATE CONTRIBUTION.—A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1903(a) with respect to contributions in excess of such limitations.

"(ii) NO FFP FOR PRIVATE CONTRIBUTIONS.—No Federal financial participation shall be provided under section 1903(a) with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

"(E) APPLICATION OF DIFFERENT MATCHING RATES.—The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1903(a) exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

"(3) USE.—

"(A) GENERAL USES.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

"(ii) GENERAL LIMITATION.—In no case shall such account be used for payment for health care expenditures that are

not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

"(iii) STATE RESTRICTIONS.—In applying clause (i), a State may restrict payment for—

"(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this title or any other health benefit program, to have failed to meet quality standards or to have committed one or more acts of fraud or abuse; and

"(II) items and services insofar as the State finds they are not medically appropriate or necessary.

"(iv) ELECTRONIC WITHDRAWALS.—The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and

shall not permit withdrawals from the account in cash.

"(B) MAINTENANCE OF HEALTH OPPORTUNITY ACCOUNT AFTER BECOMING INELIGIBLE FOR PUBLIC BENEFIT.—

"(i) IN GENERAL.—Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this title because of an increase in income or assets—

"(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

"(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

"(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits.

"(ii) SPECIAL RULES.—Withdrawals under this subparagraph from an account—

"(I) shall be available for the purchase of health insurance coverage; and

"(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

"(iii) EXCEPTION FROM 25 PERCENT SAVINGS TO GOVERNMENT FOR PRIVATE CONTRIBUTIONS.—Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

"(iv) CONDITION FOR NON-HEALTH WITHDRAWALS.—No withdrawal may be

made from an account under clause (ii)(II) unless the accountholder has participated in the program under this section for at least 1 year.

"(v) NO REQUIREMENT FOR CONTINUATION OF COVERAGE.—An account holder of a health opportunity account, after becoming ineligible for medical assistance under this title, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

"(4) ADMINISTRATION.—A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7).

"(5) TREATMENT.—Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this title.

"(6) UNAUTHORIZED WITHDRAWALS.—A State may establish procedures—

"(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

"(B) to recoup costs that derive from such nonqualified withdrawals.".

CHAPTER 5—OTHER PROVISIONS

SEC. 3141. INCREASE IN MEDICAID PAYMENTS TO CERTAIN INSULAR AREAS.

Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by inserting "and subject to paragraph (3)" after "subsection (f)"; and

(2) by adding at the end the following new paragraph:

"(3) FISCAL YEAR 2006 AND 2007 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

"(A) For the Virgin Islands, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

"(B) For Guam, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

"(C) For the Northern Mariana Islands, $1,000,000 for fiscal year 2006 and $2,000,000 for fiscal year 2007.

"(D) For American Samoa, $2,000,000 for fiscal year 2006 and $4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.".

SEC. 3142. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) GRANDFATHER.—In the case of a State that has had approved as of the date of the enactment of this Act a provider tax on services described in section 1903(w)(7)(A)(viii) of the Social Security Act, as amended by subsection (a), such amendment shall be effective as of October 1, 2007.

SEC. 3143. MEDICAID TRANSFORMATION GRANTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 3104, is amended by adding at the end the following new subsection:

"(y) MEDICAID TRANSFORMATION PAYMENTS.—

"(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments under subsection (a) to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

"(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

"(A) Methods for reducing patient error rates.

"(B) Methods for improving rates of collection from estates of amounts owed under this title.

"(C) Methods for reducing fraud and abuse under the program under this title.

"(3) APPLICATION; TERMS AND CONDITIONS.—No payments shall be made to a State under this subsection unless the State applied to the Secretary for such payments in a form, manner, and time specified by the Secretary. Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

"(4) FUNDING.—

"(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

"(i) $50,000,000 for 2006; and

"(ii) $50,000,000 for 2007.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

"(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States.

"(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

"(D) NO DOUBLE DIPPING.—Funds provided under this subsection shall be conditioned upon the Secretary receives satisfactory assurances that the aggregate Federal expenditures under such title are not greater than the amount that would be paid if such payment had been made.".

SEC. 3144. ENHANCING THIRD PARTY RECOVERY.

(a) CLARIFICATION OF RIGHT OF RECOVERY AGAINST ANY THIRD PARTY LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ", including self-insured plans" after "health insurers"; and

(B) by striking "and health maintenance organizations" and inserting "health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"; and

(2) in subparagraph (G)—

(A) by inserting "a self-insured plan," after "1974,"; and

(B) by striking "and a health maintenance organization" and inserting "a health maintenance organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service".

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (G), by striking "and" at the end;

(2) in subparagraph (H), by adding "and" after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

"(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

"(i) provide eligibility and claims payment data with respect to an individual who is eligible for, or is provided, medical assistance under the State plan, upon the request of the State;

"(ii) accept the subrogation of the State to any right of an individual or other entity to payment from the party for an

item or service for which payment has been made under the State plan;

"(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service submitted not later than 3 years after the date of the provision of such health care item or service; and

"(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim;".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section take effect on January 1, 2006.

(2) DELAYED EFFECTIVE DATE FOR CHAPTER.—in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning

after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

Subtitle B—Katrina Health Care Relief

[to be provided]

Subtitle C—Katrina and Rita Energy Relief

SEC. 3301. HURRICANES KATRINA AND RITA ENERGY RELIEF.

(a) FINDINGS.—The Congress finds the following:

(1) Hurricanes Katrina and Rita severely disrupted crude oil and natural gas production in the Gulf of Mexico. The Energy Information Administration estimates that as a result of these two hurricanes, the amount of shut in crude oil production nearly doubled to almost 1,600,000 barrels per day, and the amount of natural gas production shut in also doubled to about 8,000,000,000 cubic feet per day. The hurricanes also initially shut down most of the crude oil refinery capacity in the Gulf of Mexico

region. These disruptions led to significantly higher prices for crude oil, refined oil products, and natural gas.

(2) These production and supply disruptions are expected to lead to significantly higher heating costs for consumers this winter. The Energy Information Administration projects an increase in residential natural gas heating expenditures of 32 percent to 61 percent over last winter, with the Midwest seeing the largest increase. Winter heating oil expenditures are projected to increase by 30 percent to 41 percent over last winter, again with the Midwest seeing the largest increase. Propane expenditures for home heating are projected to increase 20 percent to 36 percent over last winter, with the Midwest seeing the largest projected increase. Expenditures for home heating using electricity are expected to increase by 2 percent to 9 percent over last winter, with the South seeing the largest increase. Overall, average home heating expenditures this winter are projected to increase about 33 percent, assuming a normal winter. These significant increases in home heating costs this winter will particularly harm low-income consumers. The Low-Income Home Energy Assistance Program is designed to assist these low

income consumers in this situation. Accordingly, Congress seeks a one-time only supplement to the Low-Income Home Energy Assistance Program fund to assist low income consumers with the additional home heating expenditures that they will face this winter as a result of Hurricanes Katrina and Rita.

(b) RELIEF.—In addition to amounts otherwise made available, there shall be directly available to the Secretary of Health and Human Services for a 1-time only obligation and expenditure $1,000,000,000 for fiscal year 2006 for allocation under section 2604(a) through (d) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(a) through (d)), for the sole purpose of providing assistance to offset the anticipated higher energy costs caused by Hurricane Katrina and Hurricane Rita.

(c) SUNSET.—The provisions of this section shall terminate, be null and void, and have no force and effect whatsoever after September 30, 2006. No monies provided for under this section shall be available after such date.